Oral presentations

Free papers 1 – 3: impact & involvement

1 INVOLVING FAMILIES AND CARERS IN LEARNING FROM DEATHS

Helen Syme, Elizabeth Rees, Anna Winfield. *Leeds Teaching Hospitals Trust*

10.1136/spcare-2020-PCC.1

Background In 2018, the National Quality Board published national guidance aiming to improve how we engage with and support families/carers after death. The guidance requires trusts to ask if families had any concerns about the care their relative received.

Method LTHT formed a multi-professional working group to implement the guidance. A new process was tested and implemented in June 2019 in which families/carers who attend the Bereavement office to collect the medical cause of death certificate (MCCD) are asked if they have any questions or feedback about the care of the person who died. This information is collected and any questions are sent to the Patient Advice and Liaison Service (PALS) to liaise with the relevant department to make contact. If any questions cannot be resolved they are escalated through the formal complaints process. Families are given contact details if they have questions at a later date. All feedback is collated by the end of life care team and fed back to clinical teams on a monthly basis.

Results Since the process was implemented, there were 943 adult deaths. Of those:

- 46 families (4.8% of deaths) had questions which were referred to PALS
- 279 families (29.5% of deaths) had positive comments about care
- 307 families (32.5% of deaths) had no comments
- 49 families fed back areas for improvement but did not want to be referred to the clinical teams through PALS.

Data is being collated to determine how many PALS escalate to a formal complaint and to establish if this new process results in fewer complaints.

Conclusions An unexpected consequence of implementing the new process has been the wealth of positive comments about the care dying patients and their families have received. Further analysis will be needed to monitor the impact on complaints and whether we are better meeting the needs of bereaved families.

2 DEVELOPMENT OF AN INTEGRATED PALLIATIVE CARE PHARMACIST ROLE ACROSS HEALTHCARE BOUNDARIES

Emma McDougall. *Northumbria Healthcare NHS Trust, Macmillan*

10.1136/spcare-2020-PCC.2

Introduction The aim of this 3 year project is to develop and evaluate the role of an integrated palliative care prescribing pharmacist, working across different settings to support patients.

Methods The pharmacist works within all areas of the palliative care team, including community, hospital liaison and inpatient palliative care unit (PCU). They contribute to multidisciplinary meetings for each of these teams, accepting

referrals for a variety of interventions, including complex symptom management, problematic polypharmacy and medication optimisation. The pharmacist visits the patient (at home, in hospital or on PCU) to discuss their medication, suggest possible changes and come to a shared decision with the patient. The pharmacist then works with teams in primary and secondary care, making interventions and suggestions in order to optimise symptom management, reduce undesirable effects and deprescribe futile medication. The patients are followed up and reassessed throughout their journey, monitoring the response to changes. They also support with the education and training of other members of staff within and outwith the specialist team, as well as contribution and development of policies, clinical guidelines, patient information and quality improvement projects.

Results From October 2018 to September 2019, the pharmacist reviewed 96 patients' medication (individual contacts: 263 contacts with patients, 38 contacts with carers, 166 contacts advising other healthcare professionals). There were 263 medication interventions, including deprescribing of 55 medications. Educational sessions delivered total 20.5 hours in a classroom environment (including medical, pharmacy and nursing audiences) and 16 hours supporting Clinical Nurse Specialists during independent prescribing qualification.

Conclusion The development of this role has supported the work of the palliative care service, and increasingly been able to provide independent reviews of patients across boundaries of community, hospital and PCU. Going forward, interventions will be assessed further to determine the impact on patient outcomes.

3 DEMONSTRATING THE IMPACT OF PALLIATIVE CARE: SECONDARY ANALYSIS OF ROUTINELY-COLLECTED CLINICAL AND PERSON-CENTRED OUTCOMES DATA AMONG HOSPICE INPATIENTS

Assem M Khamis, Andrew Bradshaw, Martina Santarelli, Kath Sartain, Alison Landon, Nigel Dodds, Rob George, Jason W Boland, Heather Richardson, Fliss EM Murtagh. *Hull York Medical School, St Christopher's Hospice*

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Background With few systematic attempts to demonstrate the impact of day-to-day palliative care in clinical services, this study aimed to demonstrate the impact of inpatient palliative care by using routinely-collected outcomes data to estimate the prevalence of symptoms/concerns, and demonstrate improvement in these outcomes over episodes of care.

Methods Secondary analysis of routinely-collected clinical and outcomes data (patients demographics, episodes of care, palliative Phase of Illness, and symptoms/concerns using the Integrated Palliative care Outcome Scale; IPOS) from all admissions to one inpatient hospice unit, between June – November 2019. We defined 'improvement in outcome' as any patient with 'moderate', 'severe', or 'overwhelming' IPOS items (scored 2,3 or 4) at start of episode of care, which improved to 'not at all' or 'slightly' (scored 0,1) by end of episode. Caldicott Guardian approval was received for analysis of this anonymized data.

Results 20,999 contact observations relating to 386 patients receiving 417 episodes of care were analysed. This incorporated 2,307 palliative Phases. Median age was 73 years (IQR 60–83); 82% had cancer.

By the end of the episode of care: